

# Lighthouse Underwriters, LLC



7630 Little River Turnpike, Suite 200  
Annandale, Virginia 22003  
www.lighthouseunderwriters.com  
(p) 703-770-3700 (f) 703-770-3720

## VitalCare APPLICATION EMPLOYED HEALTHCARE ADMINISTRATORS PROFESSIONAL LIABILITY

Each question must be fully answered. If not applicable, please state "N/A"

Requested effective date: \_\_\_\_\_

1. Name of Applicant: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ E Mail Address: \_\_\_\_\_

2. Are you a member of American College of Health Care Administrators?  Yes  No

3. Have you received formal training in Health Care Administration?  Yes  No

4. How long have you been a Health Care Administrator?  
 <1 year  1-3 years  3-5 years  5-10 years  10+ years

5. Have you been certified as a Health Care Administrator by the American College of Health Care Administrators?  Yes  No

6. How many hours of continuing education have you received in the past 24 months?  
 <8  8-15  16-23  24-31  32+

7. Are you currently employed as an Administrator?  Yes  No

8. Are you responsible for client assessment and discharge?  Yes  No

9. Are you the Administrator for more than one facility?  Yes  No  
If yes, please provide full details: \_\_\_\_\_

10. Does the facility where you work have more than 150 beds?  Yes  No  
If yes, please confirm how many beds \_\_\_\_\_

11. Name of Employer: \_\_\_\_\_

Address of Employer: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer's Professional and General Liability Insurance Company: \_\_\_\_\_

Effective Date of Professional/General Liability Insurance: \_\_\_\_\_

Professional liability insurance limits:

Limits:  \$500,000  \$1,000,000  \$2,000,000  \$5,000,000  \$10,000,000

12. Have you ever had your Administrator or Practitioner license revoked or suspended? Yes No  
If yes, please provide full details: \_\_\_\_\_
13. Have you ever been removed, fired, terminated, asked to resign, or otherwise involuntarily separated from a job in any health care facility? Yes No  
If yes, please provide full details: \_\_\_\_\_
14. Have you ever been convicted of any felony, sex offence or convicted of any misdemeanor involving or related to the possession and/or use of drugs or other illegal substances? Yes No
15. Have you ever been denied the issuance of an Administrator or Practitioner's license in any state? Yes No  
If yes, please provide full details: \_\_\_\_\_
16. Have you ever been reported to the National Practitioners Data Bank? Yes No
17. Have you ever been named personally as a defendant in a suit against a Health Care Facility or has the Facility where you are Employed ever been named in a suit? Yes No  
If yes, please provide full details: \_\_\_\_\_
18. Have you ever been personally fined, censured, reprimanded or disciplined by any regulatory or governmental agency? Yes No  
If yes, please provide full details: \_\_\_\_\_
19. Is the applicant or any other person for whom insurance is being requested, aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? Yes No  
If yes, provide full details. \_\_\_\_\_
- 

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, IT WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT, INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

\*Notice applicable in most states:

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance, or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

\_\_\_\_\_/\_\_\_\_\_  
Applicant's Signature/Title Date

\_\_\_\_\_  
Print Name